

# Streamlining Eligibility Appeals

Project Manager: Betsy Schindler

# **Streamlining Eligibility Appeals**

Betsy Schindler

South Carolina Department of Health & Human Services

Certified Public Manager Class of 2013

### Background

The South Carolina Department of Health and Human Services (DHHS) administers the Medicaid program for the state of South Carolina. Medicaid is a joint state and federal program which provides healthcare coverage for individuals including but not limited to; children, low income families, pregnant women, aged, blind or disabled individuals. Some of the Department's (DHHS') primary functions are making Medicaid eligibility determinations and overseeing payment to providers rendering care to beneficiaries.

DHHS has eligibility determination offices in every county of South Carolina and several units in the central office in Columbia. Counties are divided into eight regions with a Regional Administer for each. To apply for Medicaid, individuals can either go to their local office, mail in an application or apply online. Once eligible, beneficiaries' cases are reviewed annually to determine continued eligibility.

In Fiscal Year 2012 (7/1/11 to 6/30/12), DHHS processed 473,569 Medicaid applications and 377,339 annual eligibility reviews. The Department notifies all applicants of the outcome of their eligibility determination. The results of annual reviews are sent to the beneficiaries if eligibility is being terminated. Medicaid beneficiaries and applicants have rights, guaranteed by the Due Process clause of the 14<sup>th</sup> Amendment, to notice and a fair hearing when an adverse action is taken by the Medicaid agency. When a beneficiary appeals a decision or delay of the agency, they are requesting a fair hearing which will be heard by the Division of Appeals and Hearings. Per the 42 CFR (Code of Federal Regulations), the agency must take final administrative action (have a final decision) within ninety days of the date the Appellant filed an appeal with DHHS.

### **Problem**

The Division of Appeals and Hearings received 1,044 fair hearing requests in calendar year 2011. Of these appeals, 510 were about Medicaid eligibility issues, usually the denial of a Medicaid application or the termination of eligibility upon annual review. Applicants/Beneficiaries normally contact their Eligibility Worker in the local Medicaid office where they filed their application to request a hearing. The South Carolina Medicaid Policy and Procedure Manual directs Eligibility Workers to create an appeal summary, gather support documentation and policy to submit to the Division of Appeals and Hearings within 5 calendar days of receiving the appeal. It was apparent to the Division of Appeals and Hearings that the majority of appeals packages was not meeting the timeliness guidelines in policy and did not include all information required to evaluate appeals. This is problematic for a number of reasons, the first being federal regulations dictate the length of time allowed to issue a final decision for an appeal and second, the Hearing Officer must remain unbiased regarding the appeal and should not research or gather documentation for one party or the other.

### **Data Collection**

The Division of Appeals and Hearings has a regrettable lack of data on past appeals, in part due to a case management system with limited reporting capabilities so I gathered measureable data by pulling paper eligibility appeals filed in the first quarter of calendar year 2012. I created a spreadsheet for each month in the quarter showing the total number of eligibility appeals, if they were submitted in a timely fashion and what information/documents were incorrect or missing.

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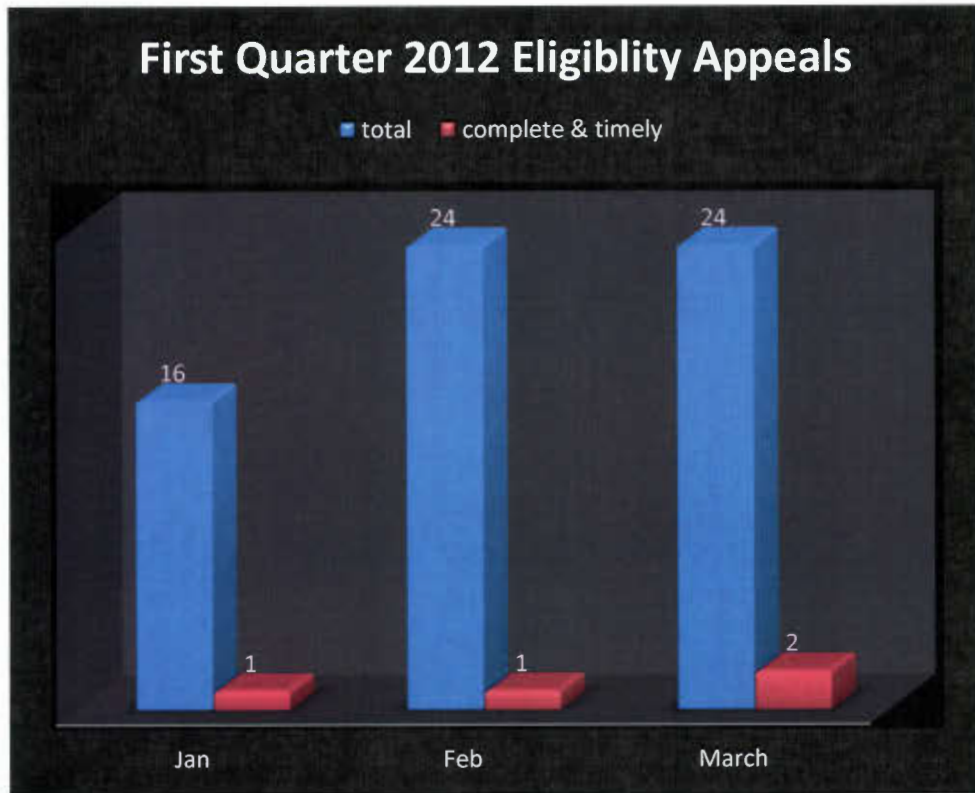
I also interviewed DHHS eligibility staff including front end workers, a supervisor and a regional administrator to reveal the reasons appeals submitted were not always compliant with agency policy.

### Data Analysis

From the first quarter data gathered I found 16 appeals were filed in January 2012 and of these, 6 were filed within the 5 calendar days allowed by policy but only 1 contained all the information needed for a Hearing Officer to be able to proceed with processing the appeal. In February, 24 appeals were forwarded to Appeals and Hearings. Six were filed timely but only 1 was complete and timely. In March another 24 appeals were submitted to Appeals and Hearings and 8 were timely with 2 having all required information and timely. Analysis of all 3 months demonstrated of 64 eligibility appeals received in Appeals and Hearings, only 4 were both timely and contained the information needed for a Hearing Officer to be able to process the appeal. This meant only 6% of the submissions were initially correct or a disappointing 94% were incorrect, allowing an opportunity for process improvement.

### 1<sup>st</sup> Quarter 2012 Eligibility Appeals

	Total	timely	complete & timely
January	16	6	1
February	24	6	1
March	24	8	2
	64	20	4



I conducted a Seven Waste/Tim Wood analysis to uncover waste in the current process. A Tim Wood analysis is a tool which helps define and measure areas in a process which are redundant or unnecessary. This allowed me to identify areas where Appeals and Hearings and Eligibility staff members had to repeatedly perform the same actions because information required was not supplied on initial submission and certain administrative tasks could have been performed more efficiently. Another waste which negatively impacts the efficiency of the appeals process is the fact that the majority of the appeals submitted are hard copies of eligibility file records so there is the added expense of the cost and storage of large volumes of paper. This analysis revealed 16 waste items.

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### Seven Waste/Tim Wood Analysis

	Type of Waste	Examples	Identified Waste in Current Project Process	Waste Items Identified
<b>T</b>	Transportation	Appeals received by local eligibility office, then distributed to the EW who must locate paper case file, gather documents, create summary and take to copier to copy, then submit to Division of Appeals & Hearings (A&H)	1. Paper-Based Processes 2. Time Consuming creating summary and compiling appeal package 3. Unnecessary documentation copied and submitted to A&H	<b>3</b>
<b>I</b>	Inventory	Volume of appeals submitted build up if not submitted to A&H in a timely manner. A&H must hold Appeals until EW submits requested documents	1. Unable to meet CFR time requirements when appeals are not submitted to A&H within time allowed by policy (5 days) 2. Chief Hearing Officer's (CHO) time wasting having to request further documentation 3. EW's time is wasted having to go back to the case file to copy requested documentation	<b>3</b>
<b>M</b>	Motion	EW -Walking to pick up appeal, locate file, make copies, take to mail	1. time wasted gathering information	<b>1</b>
<b>W</b>	Waiting	Appeal not assigned to HO, EW hold until requested documentation gathered	1. time 2. backlog of unopen cases created	<b>2</b>
<b>O</b>	Overproduction	Appeals held for further information to be submitted	1. time 2. backlog of unopen cases created	<b>2</b>
<b>O</b>	Over-processing	EW often submits identical information to that which was sent with the original appeal	1. HO's time to evaluate if requested information received 2. EW time 3. extra paper	<b>3</b>
<b>D</b>	Defects	Original submission of appeal not correct, subsequent submissions do not contain all requested information	1. CHO's time spent reviewing appeal package for missing information and requesting. 2. EW has to spend more time on appeal they previously submitted	<b>2</b>
			<b>Total Number of Waste Items Identified:</b>	<b>16</b>



To analyze the information gathered from eligibility staff, I created a Fishbone Diagram (Figure 1 page 13) to determine the root cause of poor compliance with the appeal submission policy. By interviewing the people who are responsible for creating the appeals packages, I hoped to discover why information was missing when appeals were submitted to Appeals and Hearings. This allowed me to narrow the possible causes to issues such as the increase in the number of applications due to the poor economy and no corresponding increase in the number of Eligibility Workers which in turn caused a lack of time to prepare appeals summaries. In addition, there was a the lack of familiarity with the process due to the rarity of Eligibility Workers ever having an appeal which contributed to the fact that preparing appeals packages is not a high priority activity in eligibility offices.

### Implementation Plan

Since analysis of the data showed there was plenty of room for improvement of appeals submissions, I recruited a team of key DHHS staff to brainstorm about solutions. The team was comprised of Hearing Officers, Robert French and Renee Johnson, and Medicaid Policy and Planning staff, Shearl Jones, Quality Manager, and Betty Moses, Director. Additionally, Mel Carlyle of the Office of Eligibility and Enrollment joined the team to provide information about a pilot project utilizing On Base in Greenville and Richland counties eligibility offices for the electronic filing of Medicaid applications. This pilot project will have implications on how appeals will be submitted to the Division of Appeals & Hearings as more county offices move to electronic filing so I felt it was important to include this aspect in my CPM project.



The team decided creating a checklist Eligibility Workers could use to assist them in preparing appeals was the quickest and most cost effective solution to improve compliance with appeals requirements. This checklist would detail what information to include in the appeal summary, which documents were required and the time frame allowed. After multiple revisions, the Appeals Package Checklist, form 3315 (Figure 2 page 14-15), was created and incorporated in the E-Learning program available on the DHHS Intranet for Eligibility Workers to access. Procedures for completing the form were also created and posted (Figure 3 page 16). On October 17, 2012, Betty Moses emailed eligibility supervisors statewide directing them to have their staffs to start using the form 3315 which was posted on the DHHS forms page. The cost of incorporating the form 3315 in the eligibility process was minimal because the E-Learning slide show already existed and required modification of only a few slides. DHHS eligibility forms are available on the agency intranet site and are only printed when necessary so there was little to no cost impact adding the Appeals Checklist.

### **Evaluation Method**

Evaluation of the impact of the use of the Appeals Checklist is currently ongoing. Chief Hearing Officer Robert French performs an initial review of all appeals filed with the Division of Appeals and Hearings. He is tracking the numbers of eligibility appeals received, appeals which include the form 3315 and appeals submitted to Appeals and Hearing within five calendar days from the day DHHS date stamped the appeal.

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A preliminary evaluation was conducted two weeks after initiation of use of the form to gather post implementation data for a Lean Six Sigma project. I reviewed each eligibility appeal to determine compliance with use of form 3315 and timeliness. I found that in the first twelve days after October 17, 2012, fourteen eligibility appeals were received and of these, six, or 42%, were correctly submitted with the Appeals Checklist and were timely. This demonstrates a 36% improvement. Further improvement in compliance is expected as Eligibility Workers become familiar with the new form and are reminded of the timeliness guidelines.

Tracking appeal submission compliance will be greatly enhanced when the Division of Appeals and Hearings is able to use a new On Base document management system which is currently being designed. The system will have data fields which capture information such as the date DHHS receives an appeal, the date it is received in the Division of Appeals and Hearings, if the appeal package was complete, when a final decision is issued and will allow reporting on these fields.

### Summary & Recommendations

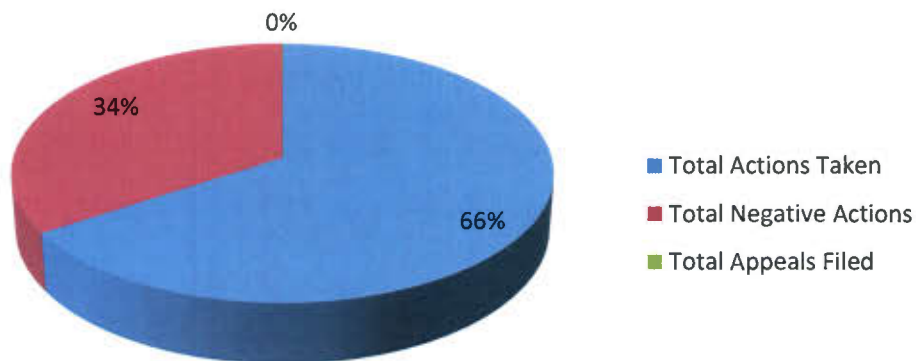
While I predict compliance with requirements for eligibility appeals will improve with the use of the Appeals Checklist, evaluation of my data leads me to draw further conclusions. In State Fiscal Year 2012 there were 850,908 eligibility actions (approvals, denials, closures or redeterminations) taken by DHHS. Of these, 444,480 were negative actions which could have led to appeals. Appeals and Hearing received 497 appeals for this time period so only .1% of all negative actions were appealed. The Department employs around 446 Eligibility Workers. The majority of appeals pertain to certain Medicaid payment categories such as Nursing Home or TEFRA (Tax

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Equity Fiscal Responsibility Act) cases which are handled by specialized Eligibility Workers who are experts in these categories. Most Eligibility Workers never receive an appeal, prepare an appeal package or attend a Fair Hearing. Since such a small percentage of negative actions are appealed, I would recommend training a small number of Quality Assurance staff placed in the Regional Offices to handle all appeals. The Quality staff could receive advanced training on preparing appeals packages and instruction on how to represent the Department in a Fair Hearing. The Quality staff could also review the case file to ensure no errors were made in processing the case that would have resulted in applicants/beneficiaries cases being approved or eligibility continued.

### Appeals for State Fiscal Year 2012



### Further Recommendations

While improving the quality of appeals summaries for eligibility appeals will improve compliance and efficiency for both the Division of Appeals and Hearings and Eligibility, the larger matter which should be addressed is how to reduce the number of appeals filed. Despite the fact less than one percent of negative actions taken by DHHS are appealed, the appeals that are filed are costly due to the work hours expended by eligibility staff and Hearing Officers. In the rare instances when all information is provided on the initial submission of an appeal, the Eligibility Worker has already invested hours of work creating the appeal package. The Hearing Officer then invest additional Department resources (computer use, paper, searches on legal research sites etc...) and hours of professional time in processing the appeal; therefore, there is value in attempting to insure each appeal is credible. An example of an implausible appeal is one resulting from a processing mistake by DHHS or legal rights of the Petitioner have been infringed upon. There is no question that beneficiaries have the right to appeal negative actions by the Department but the number of appeals filed may be greatly reduced by improving how applicants are notified of a negative action.

Currently, when an Eligibility Worker denies or terminates a case MEDS (Medicaid Eligibility Determination System) automatically generates and mails a notice to the individual. The notice letter states what action is being taken, individuals impacted, the effective date, why the action was taken, the policy related to negative action and how to appeal the action. If an individual is denied Aged, Blind or Disabled (ABD) Medicaid due to excess income the notice states "Your income is more than policy allows". The notice fails to explain how their income was

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calculated and what the income limit is for ABD Medicaid. Other notices are even more cryptic with reasons for denial/closure such as; “You had a change in an income allocation”, “Your baby does not live with you”, “You did not complete the required actions”, “We did not receive proof needed to determine continuing benefits”, “Your spouse no longer qualifies for Medicaid” and “You have not met eligibility rules”. A clear explanation of how the eligibility determination was made and why the negative action was taken would allow applicants/beneficiaries to make an informed decision on whether they feel it would be worth their time and effort to file an appeal. Changes in system requirements by CMS (Centers for Medicare and Medicaid) have mandated the Department update payment and eligibility systems. This will allow an opportunity to revise notices of negative action and clarify the wording for the reason of the denial or closure, which in turn will reduce the cost to the Department. These cost savings will result from less Eligibility and Appeals staff time being required to process appeals and will improve compliance with the CFR. Additionally, CMS conducts audits of state Medicaid Departments which can result in penalties for negative findings so cost saving could result if CMS audits conclude DHHS has correctly determined applicant/beneficiaries eligibility and properly carried out appeals while reducing the overall number of appeals filed.

### References

1. 42 CFR, Section 431.244, Hearing Decisions
2. SC Medicaid Policy and Procedure Manual, Section 101.13.10, Right to Appeal and Fair Hearing  
<http://medsweb.scdhhs.gov/mppm/mppmtoc.htm>
3. SCDHHS Medicaid Eligibility Appeals and Fair Hearings Process. Assembling the Appeals Package E-learning online for Eligibility Workers  
<https://training.scdhhs.gov/eligibility/login/index.php>

## 5 Why Analysis

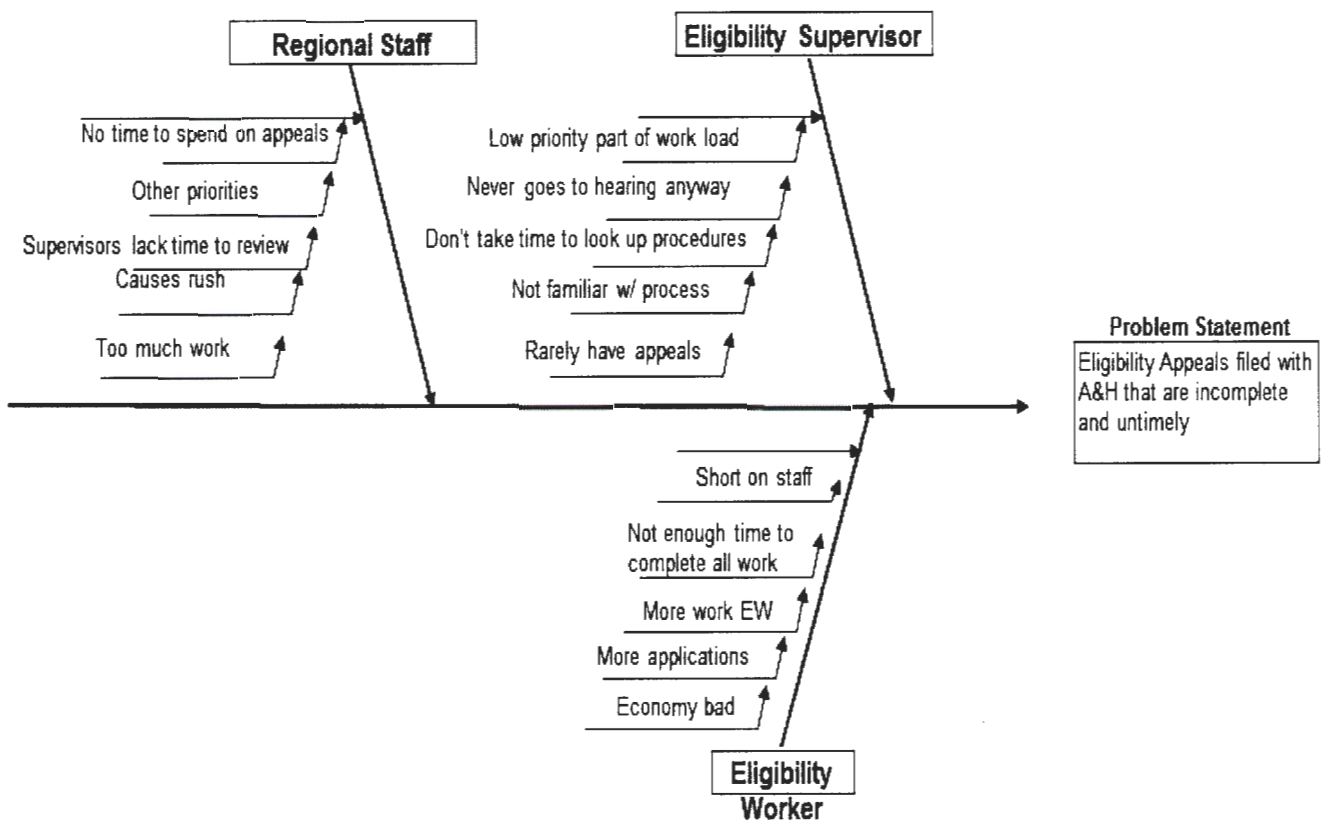


Figure 1



South Carolina Department of Health and Human Services APPEALS PACKAGE CHECKLIST		
In Packet	Not Applicable	Appeal Summary
		<b>Section I</b>
	required	Beneficiary name(s), address, phone # & payment category
	required	Medicaid recipient ID (s) & household #
	required	Date application or review was stamped as received by DHHS
	required	Name, address & phone # of the person completing appeal summary
		<b>Section II</b>
	required	Dates of actions (denial/closure/rebudget etc...)
	required	Description of specific circumstances considered when the case was processed including reason for negative action (not reason code)
	required	Statement of eligibility criteria not met
		Description of transfer/penalty determination
		Step by step explanation of how income and/or resources were determined including formulas utilized for calculations and proof COLA disregard was considered
	required	Statement of other categories considered (ex-parte determination)
		Description of determination for each month of retro-active coverage requested
		Description of details of Income Trust processing
		<b>Supporting Documentation</b>
	required	Notice to applicant/beneficiary of action being appealed
	required	Copy of the policy cited on the notice
	required	Copy of other policy pertaining to the eligibility determination
	required	Copy of Application or Review form
		Workbook to show calculations for income & resource
		Income verification
		Resources verification
		Income Trust documents
		Disability Determination
		Transfer/penalty documentation
		Notes from MEDS
		Written correspondence to/from applicant/beneficiary/third party
		<b>Submission of Appeal</b>
	required	Written appeal request from applicant/beneficiary
	required	DHHS Form 3260ME (if there is a signed appeal statement, no applicant/beneficiary signature needed on 3260 ME)
		Appeal package sent to Appeals & Hearings within 5 calendar days of receipt of appeal request
	required	Copy of entire appeal package sent to applicant/beneficiary

Figure 2 (front)

DHHS form 3315 (September 2012)

### Appeals Package Checklist Information

- The Appeals Package Checklist should be completed for each eligibility appeal received by DHHS
- Form may be completed online or a written hard copy may be submitted with the appeal package
- Appeals packages should be submitted to:

Division of Appeals & Fair Hearings

Department of Health & Human Services

Post Office Box 8206

Columbia, SC 29202-8206

- If an appeal is received for a case which DHHS identifies as requiring further processing or clarification, the appeal request must still be submitted within 5 calendar days to the Division of Appeals and Hearings with a statement that DHHS is reviewing the case details and requests the Division of Appeals and Hearings delay processing until a review has been completed
- “Required” fields are items necessary for all types of appeals. Other fields are required as they apply to the type of appeal filed- for example: the description of how income was determined and calculated would be required when the denial was due to excess income

### Procedures for Completion of DHHS Form 3315, Appeals Checklist

When an applicant/beneficiary submits a request for an appeal, the supervisor (or designee) must review the case action for accuracy, and the DHHS Form 3260, Request for Fair Hearing for Medicaid Applicant and Beneficiary for completeness. Before submitting the request to the Division of Appeals, the DHHS Form 3315, Appeals Checklist must be completed to ensure a thorough explanation and all information relevant to the negative action are included in the appeals package.

The following actions are required when completing the DHHS Form 3315, Appeals Checklist:

- The DHHS Form 3315, Appeals Checklist must be completed for every appeal
- An entry is required for every item listed on the DHHS Form 3315, Appeals Checklist
- If an item is listed as 'Required', it must be on file for all appeals
- If an item is not listed as 'Required', it is only on file if it is relevant to the negative action upon which the appeal is based.

#### Appeal Summary

##### Section I

This is the header of the appeal summary. This section provides identifying information regarding the applicant/beneficiary, and the agency as the Respondent.

##### Section II

This section is a narrative of the specific circumstances that were considered when the eligibility determination was completed. Included in this section is the specific reason(s) for the negative action, including a step by step explanation of how income and/or resources were determined, if applicable.

#### Supporting Documentation

A copy of the application/review, any notice(s) sent to the beneficiary, verification that supports the action taken, notes and correspondence, and any policy that supports the negative action is included as supporting documentation in the appeals package.

#### Submission of Appeal

The applicant/beneficiary's written request (letter or completion of DHHS Form 3360, Request for Fair Hearing for Medicaid Applicant and Beneficiary, Part II) must be included in the appeal package.

NOTE: The Petitioner should receive a complete copy of the appeal package.

Figure 3